

Date: [Insert Date]

TO: [Insurance Company Name]

ATTN: [Claims/Prior Authorization Department]

FAX: [Insert Fax Number]

RE: Letter of Medical Necessity for Custom Manual Wheelchair/Pediatric Stroller

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Policy ID: [Insert ID Number]

Diagnosis: [Insert Specific ICD-10 Code, e.g., G71.01 Duchenne Muscular Dystrophy]

To Whom It May Concern,

I am writing to formally request coverage for a custom-contoured pediatric seating system and stroller base for my patient, [Patient Name]. [He/She] has a diagnosis of Muscular Dystrophy, a progressive neuromuscular disease characterized by muscle wasting and profound weakness.

Clinical Status:

Due to the progression of this disease, [Patient Name] presents with significant trunk instability, generalized hypotonia, and poor head control. [He/She] is non-ambulatory and lacks the upper extremity strength to self-propel a standard manual wheelchair. A standard commercial stroller does not provide the postural support required to prevent skeletal deformities or maintain a functional respiratory position.

Medical Necessity and Equipment Requirements:

The following features are medically necessary for this patient:

- **Custom Seating/Contoured Supports:** To provide pelvic stability and prevent the development of scoliosis and hip subluxation.
- **Tilt-in-Space Function:** Necessary for pressure relief, managing orthostatic hypotension, and facilitating head control for safe swallowing and breathing.
- **Adjustable Positioning Components:** Including lateral trunk supports and headrest to compensate for progressive muscle weakness.
- **Portability:** A stroller-style base is required for transport to medical appointments and to allow for integration into the home environment where a full-sized power chair may not yet be accessible.

Functional Goals:

The goal of this equipment is to maintain the patient's skin integrity, improve respiratory capacity through upright positioning, and provide a safe method of transport for all activities of daily living.

Without this specialized equipment, [Patient Name] is at high risk for skin breakdown, respiratory infections, and rapid skeletal deformity. Please feel free to contact my office at [Phone Number] if further clinical documentation is required.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]